COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 29, Number 41. November 16, 2020
OIG Worksheets From Malnutrition Audit Raise Questions About Reasons for Denials, Experts Say

By Nina Youngstrom

When the HHS Office of Inspector General (OIG) declared in July that hospitals had overbilled Medicare $1 billion in two years for severe malnutrition,[1] physician James Kennedy and compliance professional Paul Belton decided to look behind the curtain at OIG's conclusions. Kennedy submitted a Freedom of Information Act (FOIA) request to OIG for the audit worksheets and got 200 summaries of the malnutrition reviews, which shed more light on what the audits potentially mean for hospitals.

What they learned: In some cases, the reviewers hired by OIG were satisfied that patients met the American Society for Parenteral and Enteral Nutrition (ASPEN) criteria for severe malnutrition and that it was documented by the physician, which would seem to bode well for the inpatient claims. But some of the diagnosis codes were rejected anyway.

"OIG often stated the complexity of the treatment didn't support their interpretation of the coding guidelines as an additional diagnosis," Belton said. That doesn't square with the definition of an additional (secondary) diagnosis in coding guidelines and the *Coding Clinic*, said Kennedy, president of CDIMD in Nashville, Tennessee. According to the Uniform Hospital Discharge Data Set (UHDDS), secondary diagnoses are defined as "other diagnoses." For reporting purposes, "the definition of 'other diagnoses' is additional conditions that affect patient care in terms of requiring clinical evaluation, or therapeutic treatment, or diagnostic procedures, or extended length of hospital stay, or increased nursing care and/or monitoring." Any one of them would allow the coding of malnutrition on the claim, which affects MS-DRG assignment because it's a major complication and comorbidity (MCC).

"The fact that the physician documented and addressed it is enough, given that the patient was clinically evaluated as to determine the presence of the documented diagnosis and treated in the safest manner possible," Kennedy said Nov. 4 on a podcast hosted by the Association of Clinical Documentation Integrity Specialists.[2] "It's codable." OIG's conclusions could be "putting uncertainty in the minds of coders," added Belton, former vice president of corporate compliance at Sharp HealthCare in San Diego who is now affiliated with CDIMD.[3]

The other tidbit they learned from the FOIA request: The malnutrition cases were reviewed by a licensed physician and coder at a zone program integrity contractor.

The OIG audit[4] has landed hard in the compliance world. OIG selected a random sample of 200 inpatient claims worth $2.9 million with discharge dates between Oct. 1, 2015, and Sept. 30, 2017. They had severe malnutrition diagnosis codes—nutritional marasmus (E41) or unspecified severe protein-calorie malnutrition (E43)—as the sole MCC. OIG's findings: Hospitals incorrectly billed 173 claims. For nine of them, documentation supported a secondary diagnosis besides severe malnutrition, and for 164 of the claims, the billing errors caused net overpayments of $914,128. OIG said hospitals should have used codes for other forms of malnutrition or no malnutrition diagnosis codes. "On the basis of our sample results, we estimated that hospitals received

overpayments of $1 billion for FYs 2016 and 2017," according to the report.

OIG recommended CMS collect the part of the $914,128 in overpayments for severe protein-calorie malnutrition and nutritional marasmus that are within Medicare's reopening period. Also, CMS should inform providers that if the audit amounts to "credible information" of potential overpayments under the 60-day rule, they should "exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule." CMS agreed.

Because of the challenges with malnutrition coding and documentation and the big dollars at stake, "compliance needs to spearhead this and walk through some traditional organizational silos," Belton said. It requires a "multidisciplinary approach" with nursing, the medical staff, nutrition, dietary, compliance and clinical documentation integrity (CDI) to establish guidelines and "champion the effort to mitigate risk."

CDI departments in particular need collaboration and coordination from compliance officers. "CDI has to be tied to the hip with the compliance officer because there is a power differential many of us in CDI have where medical staff has more power than we do," Kennedy said. "Compliance officers bring leverage to discussions and can actually call balls and strikes in setting up the structure in how this is done, because it is the role of the compliance officer to anticipate reports like this."

Kennedy and Belton encouraged hospitals to establish policies and procedures for malnutrition, which is addressed in the first quarter 2020 edition of *Coding Clinic* (pages four to seven). Otherwise, "we are rudderless in our approach," Kennedy said. Hospitals also need a "well-defined, consistent assessment tool that demonstrates that the patient meets ASPEN criteria" and that it's crystal clear the patient has malnutrition consistent with its internal policy, Kennedy said. The diagnosis should be "based on evidence the physician is monitoring the impact of dietary therapy." Also, there should be an assessment for refeeding syndrome in patients, which validates they were starving, he said. Finally, hospitals would benefit from a prebill review process for malnutrition when it's the only major complication or comorbidity, Belton said.

One 'Surprising' Denial for Patient With G-Tube

More insights about the OIG worksheets came from physician Beth Wolf, medical director for the health information management department at Roper St. Francis Healthcare in Charleston, South Carolina, after Kennedy shared 11 samples with her. "What struck home is the reviews were comprehensive, from the emergency room to discharge," Wolf said at a webinar sponsored by RACmonitor.com on Sept. 30.[5]

For seven of the 11 samples, the ASPEN criteria for severe malnutrition was not documented. In three of the other cases, "oral supplements and registered dietician monitoring were not considered highly complex interventions," Wolf said.

OIG's conclusion in the fourth case was surprising. A patient was admitted for aspiration pneumonia and stayed for nine days. The documentation showed a BMI of 21, severe orbital wasting, a 13% weight loss over one year and G-tube placement. The patient met ASPEN criteria for severe malnutrition. "Despite that description, the reviewer did not consider this a highly complex intervention and felt the treatment plan and length of stay were not affected," Wolf said. "I was a little surprised by that. It's helpful to peek behind the curtain and see how they are interpreting some of the rules they are citing related to the coding and reporting of diagnoses."

Tension Between Prevalence and Denials

Hospitals are in a quandary because severe malnutrition should be identified to improve patient outcomes, but it's a "significant audit risk," Wolf said. According to the Agency for Healthcare Research and Quality's 2016

Healthcare Cost and Utilization Project (HCUP),[6] 2.2 million adult hospitalizations were related to malnutrition, which was about 8% of the hospital stays. But the *Journal of Hospital Medicine* reported in 2013 that between 20% and 50% of adult hospitalized patients are malnourished.[7]

"It is fair to say we are underdiagnosing and undercoding it in adult patients," Wolf said. The gap between the prevalence and coding of malnutrition can be closed with nutritionist-led programs in the hospital setting.

She noted malnutrition's other side effects. According to the HCUP, length of stay is twice as long than in patients without malnutrition; 30-day readmissions are 1.6 times higher in patients with malnutrition; hospital costs are twice as much as the average cost of all hospital stays; and the death rate is three times more than the average death rate.

To help support a malnutrition diagnosis, hospitals should identify and address documentation gaps, Wolf said. One aspect is writing queries to get clarification from the physician about the diagnosis. "We want to be clear and concise," she said. "It's all about the communication. If you wouldn't stand in front of physicians and read your query out loud to them, you probably need to rethink how you're writing them."

Queries should include clinical indicators from the health record, present the facts identifying why a clarification is required and comply with the practices in the query practice brief published by the American Health Information Management Association. But steer clear of information on how the diagnosis will affect reimbursement or quality measures.

Contact Wolf at bawolfy@yahoo.com, Kennedy at jkennedy@cdimd.com and Belton at 1paulbelton@gmail.com.

1 Nina Youngstrom, "OIG: Hospitals Overbilled $1B for Malnutrition, CMS Will Recoup; Other Audits to Resume," *Report on Medicare Compliance* 29, no. 26 (July 20, 2020), https://bit.ly/33IYlHo.
2 James Kennedy, Paul Belton, Laurie Prescott, "Severe malnutrition: Review of OIG worksheets," *ACDIS Podcast*, November 4, 2020, https://bit.ly/2IuQLrV.
3 Nina Youngstrom, "Deconstructing OIG Malnutrition Denials," *Report on Medicare Compliance* 29, no. 41 (November 16, 2020).
4 Christi A. Grimm, "Hospitals Overbilled Medicare $1 Billion By Incorrectly Assigning Severe Malnutrition Diagnosis Codes to Inpatient Hospital Claims," OIG, July 2020, https://go.usa.gov/xfbJE.
5 Beth Wolf, "Severe Malnutrition: Keys to Validating Documentation and ICD-10-CM Coding," webcast, September 30, 2020, https://bit.ly/38FwACc.
6 Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, *Non-Material and Non-Neonatal Inpatient Stays in the United States Involving Malnutrition 2016*, August 30, 2018, https://bit.ly/3nh6oC2.
7 Lisa L. Kirkland et al., "Nutrition in hospitalized patient," *Journal of Hospital Medicine* 8, no. 1 (January 2013), 52-58, https://doi.org/10.1002/jhm.1969.